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Why is Wealthier Healthier?

By Lucy Barnes, Peter A. Hall, and
Rosemary C.R. Taylor

“Wealthier is healthier.” This characteristically pithy observation by Lant Pritchett and Lawrence H. Summers (1993) summarizes one of the most firmly-established findings about population health. Health is closely related to social class. This “health gradient” shows up in all the developed democracies. On a wide variety of measures, people of higher socio-economic status tend to be healthier than those on the lower rungs of the socio-economic ladder.

The health gradient has long been of interest to social epidemiologists, but it contains puzzles that deserve the attention of many social scientists. We have been living through a neo-liberal era of rising inequality in many nations, and few social inequalities are more pernicious than those affecting health. What generates health inequalities? How can they be mitigated? These questions should concern all of us, and, they raise general issues – bearing on the constitution of societies and the sources of inequality –

of longstanding interest to social scientists. The object of this essay is to introduce some of the puzzles generated by the health gradient that deserve the attention of scholars studying the developed democracies of Europe.

The first of these puzzles is naturally intriguing for comparativists. Although the health gradient can be found in every European society, its shape varies dramatically across them. As figure 1 indicates, there are three relevant types of variation. In countries such as Ireland, the *overall shape* of the gradient is flatter than it is in other countries, such as Germany, where the health of the working class is considerably worse relative to the health of the upper and middle classes. In general, these gradients are fan-shaped, which is to say, they flatten out at some point where the differences in health corresponding to class position become less stark. However, the *threshold* at which relatively poor health outcomes give way to better health can lie at higher or lower class positions, as it does, for instance, in France and the Netherlands. At stake here is the relative health of the middle classes compared to the businessmen and professionals in the

social ranks above them. Finally, the *overall height* of the curve can vary across countries. Although the distribution of health across classes is roughly similar in Ireland and the Netherlands, for instance, respondents

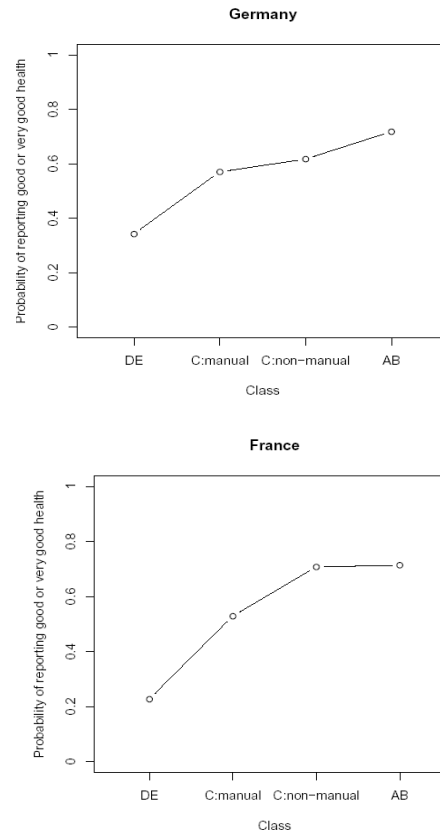
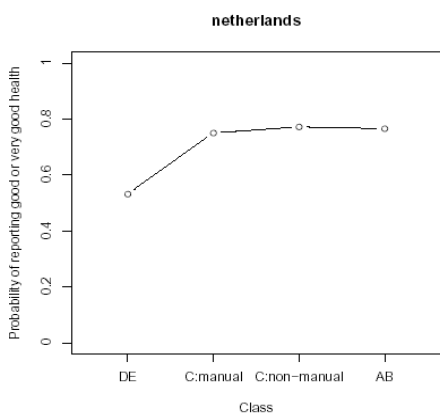


Figure 1. The shape of the health gradient in European countries (*Source: World Values Survey 1990; authors' calculations*)

at most class positions in Ireland report better health than those in the Netherlands. How is variation along these three dimensions to be explained?

Of course, there are measurement issues here. Figure 1 is drawn from the 1990 wave of the *World Values Survey*. The horizontal axis reports class position

as coded in that survey and the vertical axis indicates the percentage of respondents reporting they are in good or very good health. Self-reported health is a good indicator of health. In some studies, self-reported health has proved superior even to reports from a respondent's physician, but it is not perfect. The Irish may not be healthier than the Dutch, but simply less inclined to admit they are in poor health. A real need exists for better cross-national data about these matters.

The resolution to puzzles about the shape of the gradient will depend, however, on finding answers to an even more fundamental puzzle: How is this health gradient generated in the first place? Why do people in lower class positions tend to suffer from worse health than those in higher class positions? Social epidemiology is dominated by studies that give two kinds of answers to that question, but the inquiry should go beyond the perspectives embodied in each.

The quotation at the beginning of this article reflects the classic approach often taken to this question. Many scholars argue that inequalities of health are rooted in inequalities of wealth or

income. There is surely some truth in such explanations, but precisely why this relationship should always hold is not so clear. People with low incomes and few assets will have more difficulty securing clean housing, nutritious meals, a pollution-free environment, and the time for relaxation that contribute to good health. In the developed democracies, however, except for those in abject poverty, most people in the lower half of the social pyramid have access to the basic requisites of material life. While undoubtedly important, such *materialist explanations* do not seem entirely adequate for explaining the variation found along the health gradient. Ultimately, they explain too little.

In recent years, a second approach to this puzzle has emerged from social epidemiology. Its most prominent exponents, such as Michael Marmot (2004) and Richard Wilkinson (2005), seek a *psychosocial explanation* for the gradient, emphasizing the impact social status might have on health. They are inspired by the famous Whitehall studies that examine the health of people at different ranks in the British civil service. Those studies reveal that, even when a wide range of factors normally

associated with health are controlled, those in the lower ranks of the civil service have poorer health than those at higher ranks. People of lower status may suffer feelings of relative deprivation and status-induced anxiety that a growing body of science links to physiological processes in the hypothalamic-pituitary-adrenocortical systems associated with illness and mortality. Such arguments dovetail nicely with the intriguing finding that non-human primates with low status in their tribes also suffer from afflictions linked to these physiological systems.

From the perspective of comparative social science, however, the psychosocial approach explains too much. If inequalities in health are a function of status orders that are a feature of every society, how are we to explain cross-national variations in the shape of the health gradient? One way to do so would be to seek systematic differences in the shape of this status order across societies. In order to do so, however, we would need to see this status order as something other than a natural component of all societies. We would have to understand how and why the status order varies across societies,

which entails moving beyond psychosocial approaches toward structural conceptions of the social order. This move is precisely what a recently-published book, to which we have contributed, does. *Successful Societies: How Institutions and Culture Affect Health* () is a pioneering effort by a diverse group of social scientists to broaden conceptions of the social determinants of population health. Our formulations are inspired by their essays, and we are currently attempting to test some of the book's main propositions against cross-national data.

Our starting point is a model, outlined in the *Successful Societies* book, suggesting that a person's health is likely to be affected, over the long term, by regular experiences of stress and the emotional reactions of anxiety, anger and frustration that accompany them. Research indicates that such experiences take a toll on the physiological systems regulating health. Thus, the wear and tear of daily life can have long-term effects on a person's health. Our premise is that how much wear and tear each person experiences is, in turn, a function of the balance between the magnitude of the life *challenges* he or she faces and

that person's *capabilities* for coping with them. What are the factors that condition these challenges and capabilities? Our intuition is that some are rooted in the social and economic structures of a society. If so, a better understanding of those structures may contribute to explanations for national variation in the health gradient.

Based on the work done in the *Successful Societies* project, we think that every society embodies a specific structure of economic relations and an analogous structure of social relations. The structure of economic relations distributes income and autonomy at work (as well as other goods). In countries where those goods are more evenly distributed, health inequalities should be lower, because income and workplace autonomy enhance the capabilities that feed into a person's health.

The structure of social relations in a nation is constituted by its status hierarchy, the networks of social connections linking people, and what Gérard Bouchard has described as its collective imaginary, constituted by symbolic representations specifying who belongs to the community, the members'

rights and obligations to each other, and the community's collective purposes. From their position in this structure of social relations, people draw social resources that enhance their capabilities for coping with life challenges. Membership in social networks supplies logistical and emotional support. A higher rank in the status hierarchy makes securing the cooperation of others easier. The collective imaginary provides a sense of belonging. Like the structure of economic relations, however, the structure of social relations distributes such resources unevenly across a nation's population. Where that distribution is more unequal, we expect to see higher inequalities in health.

Although we have expressed these points synoptically, they provide an alternative to materialist and psychosocial explanations for the existence of the health gradient and for cross-national variation in the shape of that gradient. From this perspective, many inequalities in health are rooted in structural features of economic and social relations that distribute economic and social resources unevenly, thereby affecting the balance

**Table 1. The effect on health
of changes in economic and social
resources (first differences)**

Percentage shift in the likelihood of poor health associated with the following changes:		
<i>Level of education</i>		
Left school at 21 vs. 18		0 %
<i>Connections to family</i>		
Move from important to unimportant		6 %
<i>Connections to social networks</i>		
Respondent now reports feeling lonely		11 %
<i>Autonomy at work</i>		
Move from 25th to 75th percentile in autonomy		- 3 %
<i>Gender</i>		
Male to female		2 %
<i>Income</i>		
From 25th to 75th percentile		- 3 %

Self-Mastery

From 25th to
75th percentile - 3 %

National belonging

From high to low
feeling of belonging 3 %

*Source: World Values Survey 1990;
logistic estimations.*

between life challenges and capabilities present for people at different social positions, with consequences for the amount of wear and tear they experience in daily life. In this view, the structure of a country's social relations is as important as its structure of economic relations to inequalities of health.

Is this approach plausible? In order to assess it, we have estimated the impact on health of the various types of economic and social resources available to a person by virtue of his or her position within the structures of economic and social relations. Table 1 reports the results for pooled national samples drawn from fourteen developed democracies, where the dependent

variable is self-reported health. Based on first differences, table 1 indicates the percentage change in the likelihood of reporting poor health when the social or economic resources available to an average person change as indicated.

Some results from this estimation are striking. Resources rooted in the structure of economic relations, such as income or workplace autonomy, matter to a person's health. However, access to social resources, of the sort reflected in family ties, social connections and feelings of national belonging, has an even stronger effect on health. Material factors alone cannot explain health inequalities.

Our control variables – age, gender and sense of self-mastery, an indicator for the features of personality that condition capabilities – have effects one might expect. However, level of education is not statistically significant, which is a puzzling finding, given the many policymakers who believe that educating the populace more fully is one of the most promising ways to improve health outcomes. Of course, these results should be treated as purely exploratory.

Full assessment of such propositions will require much more empirical research.

However, these findings are tantalizing. They suggest that a person's health depends on access to social as well as economic resources. And, in the developed democracies, as table 2 indicates, social, as well as economic, resources are distributed unevenly across social classes. We conclude that the roots of the health gradient lie, not only in the structure of economic relations, but in the structure of social relations as well.

In a brief essay, we cannot resolve the other puzzle noted here, namely, how to explain variations in the shape of the health gradient across nations. Yet our results have intriguing implications for this puzzle. Many scholars explain national differences in health inequality by reference to variations in the distribution of income, and our results offer some support for that view. However, our results suggest that the structure of a nation's economy may affect health in other ways, notably by virtue of how it conditions the distribution of job autonomy.

Table 2. The distribution of health, economic and social resources across social classes

	Poor health	Level of edctn	Self-Mastery	Income	Job control	Ties to family	Socially connected	Assoc member	National belonging
Social class	%	Years	Mean	USD	Score	% Yes	% Yes	Mean No.	% High
Unskilled manual (DE)	28	15.6	59	9,470	6.1	85	78	0.96	86
Skilled manual (C man)	26	16.6	62	11,898	6.5	88	79	1.25	84
Lower-level white collar (C non-man)	22	18.7	66	14,295	7.0	91	85	1.59	84
Managerial-Professional (AB)	15	21.6	73	21,829	7.2	92	88	2.07	87

Source: World Values Survey 1990; pooled sample.

Moreover, variations in the shape of national health gradients may be rooted, as well, in cross-national variation in the structure of social relations. For any country, for instance, we should ask: How dense is the network of social connections at the bottom of the social ladder compared with those at the top? Where members of the lower social classes suffer from especially low levels of social connectedness or unusually low levels of social status, inequalities in health may be especially high. National variations in social structure could be as important to health inequality as national differences in the structure of economic relations.

To know whether such propositions hold more generally, however, will require cross-national comparisons of social structure – a topic somewhat neglected by contemporary social science. There is much that should attract scholars of Europe to the study of inequalities in health. Population health is not just about health care systems. By turning their attention to these questions, social scientists can secure new vistas on many kinds of issues that will broaden overall perspectives in their fields.

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